BP-A1146
OCT 22

Medication Assisted Treatment (MAT) Agreement

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(PRINT) Inmate Name (Last, First)	**Register Number**	**Institution**

I am aware that a substance use disorder is a treatable chronic disease that can include physical withdrawal symptoms, cravings for use of a drug, and feeling the need to use it while knowing that it may cause harm. I am also aware that having a substance use disorder is more common in a person who has a family history or personal history of these issues. I therefore agree to provide all my personal and family history of drug and alcohol use, to the best of my knowledge.
I also understand that the use of any of the three FDA approved forms of treatment for Opioid Use Disorder (OUD) could increase certain risks or side effects including:

- Nausea/Vomiting, Constipation, Sweating/Flushing
- Dizziness, Sleepiness, Confusion, Impaired judgment
- Dependence, Tolerance, Addiction
- Allergic reactions, Overdoses, Fatal complications

Given the above, I now agree to the following guidelines to maintain my safety while on treatment for OUD:

1. I agree not to sell, share, or give my medication to another person. Such conduct may result in immediate termination of my current treatment.
2. I will comply with all urine drug screens as often as requested by my provider and I am aware that I may also be requested to be witnessed by a same-sex staff member when I provide my urine samples. Refusing or tampering with a urine drug screen at any time may result in termination of my current treatment.
3. I agree to take the medication offered only as prescribed at the specified pill line, that I will comply with mouth checks as requested, and I agree to follow all directions and/or restrictions of monitoring for 30 minutes post administration.
4. I agree to notify medical staff immediately in case of recurrence of drug use, which can be life threatening.
5. I agree to attend individual and/or group treatment sessions and follow all recommendations from any of my treatment team that will assist in my recovery.
6. I will not interfere with another's recovery in any way and respect the privacy and confidentiality of all participants.
7. I understand that this agreement does not exclude me from complying with the Inmate Discipline Program.

☐ **I have discussed the risks, benefits, side effects, and alternatives to treatment for OUD today with my provider.**
☐ **I have had an opportunity to ask questions and receive answers to those questions to my full satisfaction.**
☐ **I am signing this form voluntarily to consent to all guidelines above while I am receiving treatment for my OUD.**

Inmate Signature	Inmate Printed Name	Date
Provider Signature	Provider Printed Name	Date

Prescribed by P6360